The Importance of Social Support for Students with Intellectual Disability: An Intervention to Promote Mental Health and Well-Being

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Abstract

Children and adolescents with intellectual disability have higher rates of mental health problems compared with their typically developing peers. Social support has been identified as an important protective factor for psychological well-being. In this paper we discuss the benefits of social support networks, and consider approaches for promoting children's perceptions of the availability of social support. We describe an evidence-based intervention that has been specially adapted and implemented for students with intellectual disability in school settings. In a randomised controlled trial, the Aussie Optimism Resilience Skills Program was associated with improved perceptions of social support following a 10 week intervention. Educators need to be aware of the increased vulnerability of students with intellectual disability to the development mental health problems and the proactive ways in which they can promote psychological well-being within their classrooms.

Introduction

Child and adolescent mental health problems are being increasingly recognised worldwide. Evidence from epidemiological studies has established psychiatric disorders as a leading cause of distress for individuals and families, as well as being a significant economic burden on the community (Costello, Egger, & Angold, 2005). Some studies claim that there has been an increase in mental health problems for young people (Collishaw, Maughan, Goodman, & Pickles, 2004; Patel, Flissher, Hetrick, & McGorry, 2007) although others dispute this (Costello, Foley, & Angold, 2006). Nevertheless, there is strong evidence of the existence of high levels of psychiatric problems by the adolescent years (Briggs, 2009; Flett & Hewitt, 2013) with up to 22% of young people meeting criteria for a mental health disorder (Merinkangas et al., 2010). Of particular concern is evidence of even higher rates of emotional and behavioural disturbance in children and adolescents with intellectual disability compared with their typically developing peers (Einfeld et al., 2006), and the likelihood that these problems will continue into adulthood (White, Chant, Edwards, Townsend, & Waghorn, 2005).

An important focus of research with vulnerable populations has been the identification of protective factors that can buffer the impact of risk on mental health. One of the most important protective factors is social support. In this paper, we discuss social support as a protective factor for the mental health and well-being of children and adolescents with intellectual disability. We consider the types of interventions that may be useful, and provide an example of the way in which an established intervention can be successfully adapted and implemented for students with intellectual disability in school settings.

Intellectual Disability and Mental Health

Children with intellectual disability have prevalence rates of mental health problems that are at least twice those found in the general population of young people (Einfeld, Ellis, & Emerson, 2011). In the Longitudinal Study of Australian Children (LSAC), although children with intellectual disability accounted for only 15% of the study population, they made up 40% of the total psychiatric morbidity for their age group (Emerson, Einfeld, & Stancliffe, 2010). The chronic co-morbidity of intellectual disability and psychopathology is commonly observed around the globe. Particularly concerning is the fact that mental health problems, which are often functionally impairing, can be difficult to identify in this population (Hassiotis & Turk, 2012) and thus often remain untreated. Mental illness adds to the challenges already faced by students with intellectual disability who have inherent impairments in cognitive and adaptive functioning, often in combination with problems in communication, attention, self-regulation and behaviour (Emerson et al., 2010; Harris, 2006). In particular, social difficulties are likely to limit access to social support which is an important protective factor for mental health and well-being.

Protective Factors and the Importance of Social Support

Despite the many risk factors associated with intellectual disability, some individuals do considerably better than others. There are two models which can explain this: one the "challenge" model whereby risk factors are associated with health outcomes, and the other the "protective" model where protective factors neutralise the effect of risk factors or enhance other protective factors (Tandon, Dariotis, Tucker, & Sonenstein, 2013). As demonstrated for typically developing children and adolescents, more positive outcomes in those with intellectual disability are probably attributable to a combination of protective individual characteristics (e.g., social competence, easy temperament and mastery orientation) and protective features of environments (e.g., family cohesiveness, positive school experiences and good social support networks).

Research has established that social support can be a protective factor for typically developing young people's mental health (Demaray, Malecki, Davidson, Hodgson, & Rebus, 2005). Social support is a multi-dimensional concept that describes emotional and physical comfort provided to individuals by other people (Israel & Schurman, 1990). Three domains are postulated to comprise social support: emotional support, tangible support and informational support (Tandon et al., 2013). For children and adolescents, there are three sources of support: families, peers and teachers (McLaughlin, Miller, & Warwick, 1996). Each has been found to have differential effects. Peer support is a significant unique predictor of life satisfaction and internalised symptoms in early adolescence, while teacher support uniquely predicts externalising symptoms (Stewart & Suldo, 2011). However, parent support is the strongest predictor of all symptoms of mental health.

In studies of typically developing students' school engagement, different sources of social support have been found to have differential effects. Parental support was shown to foster adolescents' school engagement and outcomes (Simons-Morton & Chen, 2009) and to enhance academic motivation (Wentzel, 1998). Peer social support was associated with more behavioural and emotional engagement with school (Garcia-Reid, 2007); while teacher social support increased students' liking of school (Stipek, 2002). In a study by Wang and Eccles (2012) teachers, peers and parents were shown to play independent roles in adolescents' school engagement which were interpreted as having additive effects in terms of social support. These findings highlight the need to promote children's and adolescents' awareness of the many and varied sources of social support that are potentially available to them.

Social support has been shown to be a mediating factor for typically developing adolescents' life satisfaction (Kapikiran, 2013) and for internalising and externalising disorders (Tandon et al., 2013). It is also a strong predictor of adaptation in early adolescence (Malecki & Demaray, 2006; Rueger, Malecki, & Demaray, 2010). Research has also shown

that one does not necessarily have to receive the social support to experience the beneficial outcomes; rather, it is the *perception* of social support that seems to be important (Haber, Cohen, Lucas, & Baltes, 2007). Perceptions about the availability of social support have been linked to psychological well-being in a range of studies with typically developing children (e.g., Okawa et al., 2011). For adolescents, perceived social support has been associated with less hopelessness (Savi-Cakar & Karatas, 2012) and lower levels of internalising and externalising symptomology (Carlton et al., 2006). This perception also mitigates the negative impact of stressful events, and speeds recovery for children even if the support is not used or is not actually available (Costello, Pickens, & Fenton, 2011). Thus having the belief that there are people to turn to for help, even if it is not true or the social support is not accessed, appears to lead to better mental health outcomes.

There seems, however, to be a dearth of studies about the experiences, perceptions and benefits of social support for individuals with intellectual disability. Most research has focussed on social support for *families* of children with intellectual disability, rather than for the children themselves (Cakaytar, Ceyhan, & Adiguzel, 2012). However, a small amount of work has been done with adolescents and adults. Lunsky and Benson (2001) demonstrated links of social support to improved psychological well-being for adults with intellectual disability while Lozano (1999) investigated perceptions of social support reported by adolescents with mild intellectual disability. In the latter study, 184 young people, aged from 14 to 17 years completed a semi-structured interview and reported perceptions of their social support. It was found that both high parent and high peer support were associated with fewer mental health problems, as demonstrated in prior studies with typically developing adolescents. Additionally, high perceived parental support was associated with fewer parent reported problem behaviours and better social functioning.

Interventions for Enhancing Perceptions of Social Support

For individuals with intellectual disability, interventions that aim to prevent the development of behavioural and psychiatric disorders by building resilience are crucial since mental health problems tend to be stable across childhood (Wallander, Dekker, & Koot, 2006) and to persist into adulthood (Honey, Emerson, & Llewellyn, 2011). School delivered programs are ideal for universal intervention (Misfud & Rapee, 2005). For typically developing children and adolescents, prevention programs for anxiety and depression (the most prevalent of the mental health problems in young people) usually address multiple psychosocial and interpersonal risk factors, and include a focus on building social support networks (Gillham, Shatte, & Freres, 2000).

One such program is the Resourceful Adolescent Program (RAP) which is a universal primary prevention program to reduce the risk of adolescent depression by teaching positive coping skills, focussing on cognitive-behavioural and interpersonal therapy methods (Shochet et al., 2001). The program has been shown to lower levels of depressive symptomology and hopelessness both at post-intervention and at 10-month follow-up compared to a comparison group (Shochet et al., 2001) and to reduce anxiety and depression in typically developing adolescents (Muris & Hoogsteder, 2001).

One of the ten modules in RAP focuses specifically on building social support networks, with the emphasis on having people one can turn to for different problems and on different occasions. The RAP program also has strong leader-student and peer-peer interpersonal components which demonstrate positive social support (de la Haye, 2011). This program, however, has not been modified for and trialled with students with intellectual disability. Other examples of anxiety and depression prevention programs for typically developing children are Friends for Life (Barrett, 2004) and Cool Kids (Rapee, Wignall, Hudson, & Schniering, 2000). Both include psycho-education about anxiety, social skills and assertiveness. Although neither program has been researched with students with an

intellectual disability, both have been positively evaluated in low socio-economic areas which have an association with intellectual disability (Misfud & Rapee, 2005; Stopa, Barrett, & Golingi, 2010).

Thus, despite the plethora of available evidence-based programs, resilience-building interventions designed specifically for children with intellectual disability are scarce. Although it may be presumed that children with intellectual disability who participate in general interventions benefit in similar ways to their typically developing peers, as far as we know evidence to support these assumptions has not been documented. We believe that children with intellectual disability are likely to gain more benefit from programs that are specially designed or modified, for instance by reducing the complexity of concepts, slowing down the rate of presentation, and incorporating components that address issues that may be particularly problematic for children with intellectual disability.

Unfortunately, the prevailing philosophy of inclusion for children and adolescents with intellectual disability in mainstream schools is that prevention and intervention programs for mental health are conducted in the same classroom for both typically developing students and those with an intellectual disability. Perhaps students with intellectual disability do benefit from these programs but to our knowledge there have been no attempts to analyse and report the results of interventions separately for children with and without intellectual disability. This “one size fits all” approach is predicated on the false assumption that mainstream services can provide adequately for individuals with intellectual disability, without any recognition of, or adjustments to cater for, their special needs and with no specialised expertise on the part of the service providers (Torr, 2013). Within intervention research, however, one program has been successfully adapted for children and adolescents with intellectual disability.

Aussie Optimism: An Intervention Adapted for Children with Intellectual Disability

Aussie Optimism (Roberts, Ballantyne, & van der Klift, 2002) is an established program that aims to promote mental health and well-being, and to prevent emotional problems such as depression and anxiety in typically developing children and adolescents. In studies with typically developing children, the intervention has been associated with reductions in anxiety and depression (Roberts, Kane, Bishop, Cross, Fenton, & Hart, 2010; Roberts, Kane, Bishop, Matthews, & Thompson, 2004). In addition, short-term improvements in social skills have been reported following the intervention (Mills, 2007) and there appear to have been benefits also for children with conduct disorders (Swannell, Hand, & Martin, 2009) and for those involved in substance abuse (Roberts et al., 2011).

Aussie Optimism was adapted in various ways and named the Aussie Optimism Resilience Skills Program (AORS) for students with an intellectual disability (Roberts et al., 2009). The content of the intervention was taken from the original Aussie Optimism program and adapted to increase its appropriateness for children with intellectual disability in the final years of primary (elementary) school (i.e., age approximately 11-13 years). Instructions were simplified. For example, “describe a situation when you were happy” became “write or draw a time when you were happy” and concepts that were somewhat vague or abstract were explained more clearly and concretely. For example, when discussing important behaviours that let someone know you are listening to them, “show you’re interested in the other person” was expanded to “show you’re interested in the other person by the look on your face” and combined with modelling of appropriate facial expressions. Another modification involved giving clearer and more concrete examples to reduce the complexity of the concepts. As it was anticipated that many students with intellectual disability would have limited literacy skills, wherever possible student workbooks included the option of drawing pictures rather than writing.

In addition, the method of program delivery was modified. Instead of being packaged as an hourly session as required in the original Aussie Optimism, each module was designed to be broken down into shorter sessions. Given their slower pace of learning, more limited capacity for sustained attention, and greater need for repetition to consolidate new learning, children with intellectual disability were expected to master content more effectively if each module was split across two or more shorter sessions during a single week. Some activities were changed to account for the fact that they would be presented to small groups of 2 to 6 children, rather than whole classes of 20 to 25 students.

The final adapted version of the Aussie Optimism program for children with intellectual disability contains 10 modules covering feelings, coping skills, problem solving, communication skills, social skills, assertiveness, negotiation, networks, friends and families, transitions and review. Three of these modules help students to develop specific interpersonal relationship skills such as friendly habits, assertive ways of communicating, and negotiation. Children learn to apply these skills to their peer and family relationships in order to develop networks and social support. For example, in the networks module the purpose is for students to identify times of need, and to "to know and understand that there are people around them who can help in times of trouble and delight in their successes" (Roberts et al., 2009, p. 99). They learn to identify their own support networks by drawing a "circle of help" or a "hand of support". The circle of help begins with the child drawing him/herself in a centre circle which is then surrounded by a series of concentric circles. The closest circle to the child contains people who are the first and most intimate sources of support – members of the nuclear family. Surrounding this circle is the next level of support – close friends and extended family; then comes a circle with helpers such as teachers, and counsellors; followed by a circle of more distal supports including community workers and police. Teachers assist

the students to discriminate these varying levels of support, and also to distinguish appropriate support people from strangers.

Effectiveness of Aussie Optimism for Children with Intellectual Disability

The adapted Aussie Optimism was trialled with 110 children (41 girls, 69 boys) with intellectual disability aged 9 to 13 years (mean age = 11 years 10 months) (REMOVED FOR BLIND REVIEW). The children were all attending mainstream classes in Australian schools, and the majority had a mild intellectual impairment. The study involved a randomised controlled trial in which 63 students were randomly assigned to the intervention and 47 were wait-listed to receive the intervention at a later time. Measures of resilience and mental health were obtained before commencement of the intervention, soon after its conclusion, and approximately six months later following the children's transition to high school.

There was a significant intervention effect for the protective factor of perceptions of social support. After completing the intervention, children obtained significantly higher scores compared with the non-intervention group. They reported more confidence that support would be available from their friends or families if they needed it. Their more positive responses to questions such as *There are people who love and care about me*, *If I get upset or angry, there is someone I can talk to,* and *If something bad happens, I can ask my friends for help*, suggested that the intervention increased their awareness of the availability of help. Although this perception does not necessarily mean that children will actually ask for help, simply knowing that support is available may be as important, or even more important, in terms of its protective value for mental health. Being aware that there is someone who cares and who will help if required is likely to give children a sense of security and confidence. In addition, this awareness is likely to lead to actual help-seeking when in need

of support, and a greater uptake of the social supports that are important for helping individuals to cope with mental health problems. Although the intervention group did not demonstrate any improvements in mental health (e.g., reductions in depression and anxiety), it is reasonable to assume that over time the perception that support is available and the actual experience of support will have positive benefits for mental health.

Conclusions

It is important for special educators to be aware of the increased vulnerability of students with intellectual disability to the development of mental health disorders. We have drawn particular attention to the potential role of social support as a protective factor for children's psychological wellbeing. Although we argue that there is a need for evidence-based interventions that are specially adapted for the needs of students with intellectual disability, in the absence of such programs teachers can still address mental health and well-being proactively, for instance by embedding activities such as the circle of help within other lessons.

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